SERFF Tracking Number:	*UHLC-127355610*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare of Arkansas, Inc.*	*State Tracking Number:*	*49472*
Company Tracking Number:	*UHC/FPA.AMDT.MEDNEC.07.11*		
TOI:	*HOrg03 Health - Other*	*Sub-TOI:*	*HOrg03.000 Health - Other*
Product Name:	*UHC/FPA.Amdt.MedNec.07.11*		
Project Name/Number:	*UHC/FPA.Amdt.MedNec.07.11/UHC/FPA.Amdt.MedNec.07.11*		

Filing at a Glance

Company: UnitedHealthcare of Arkansas, Inc.

Product Name: UHC/FPA.Amdt.MedNec.07.11	SERFF Tr Num: UHLC-127355610	State: Arkansas
TOI: HOrg03 Health - Other	SERFF Status: Closed-Approved-Closed	State Tr Num: 49472
Sub-TOI: HOrg03.000 Health - Other	Co Tr Num: UHC/FPA.AMDT.MEDNEC.07.11	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Author: Kelly Smith	Disposition Date: 08/08/2011
	Date Submitted: 08/04/2011	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: UHC/FPA.Amdt.MedNec.07.11	Status of Filing in Domicile: Not Filed
Project Number: UHC/FPA.Amdt.MedNec.07.11	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small
Group Market Type: Employer	Overall Rate Impact:
Filing Status Changed: 08/08/2011	
State Status Changed: 08/08/2011	Deemer Date:
Created By: Kelly Smith	Submitted By: Kelly Smith

Corresponding Filing Tracking Number: UHC/FPA.Amdt.MedNec.07.11
PPACA: Not PPACA-Related
PPACA Notes: null
Filing Description:
Amendment to hospital contracts to support the deployment of the medical necessity initiative for commercial and Medicare members.

Company and Contact

Filing Contact Information

SERFF Tracking Number:	*UHLC-127355610*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare of Arkansas, Inc.*	*State Tracking Number:*	*49472*
Company Tracking Number:	*UHC/FPA.AMDT.MEDNEC.07.11*		
TOI:	*HOrg03 Health - Other*	*Sub-TOI:*	*HOrg03.000 Health - Other*
Product Name:	*UHC/FPA.Amdt.MedNec.07.11*		
Project Name/Number:	*UHC/FPA.Amdt.MedNec.07.11/UHC/FPA.Amdt.MedNec.07.11*		

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Filing Company Information

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Little Rock, AK 72205
(952) 992-7428 ext. [Phone]

CoCode: 95446
Group Code:
Group Name:
FEIN Number: 63-1036819

State of Domicile: Arkansas
Company Type: HMO
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
UnitedHealthcare of Arkansas, Inc.	$50.00	08/04/2011	50380947

SERFF Tracking Number:	*UHLC-127355610*	*State:*	*Arkansas*
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	08/08/2011	08/08/2011

SERFF Tracking Number:	*UHLC-127355610*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare of Arkansas, Inc.*	*State Tracking Number:*	*49472*
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TOI:	*HOrg03 Health - Other*	*Sub-TOI:*	*HOrg03.000 Health - Other*
Product Name:	*UHC/FPA.Amdt.MedNec.07.11*		
Project Name/Number:	*UHC/FPA.Amdt.MedNec.07.11/UHC/FPA.Amdt.MedNec.07.11*		

Disposition

Disposition Date: 08/08/2011
Implementation Date:
Status: Approved-Closed
HHS Status: HHS Approved
State Review: Reviewed-No Actuary
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*UHLC-127355610*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare of Arkansas, Inc.*	*State Tracking Number:*	*49472*
Company Tracking Number:	*UHC/FPA.AMDT.MEDNEC.07.11*		
TOI:	*HOrg03 Health - Other*	*Sub-TOI:*	*HOrg03.000 Health - Other*
Product Name:	*UHC/FPA.Amdt.MedNec.07.11*		
Project Name/Number:	*UHC/FPA.Amdt.MedNec.07.11/UHC/FPA.Amdt.MedNec.07.11*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Form	UHC/FPA.Amdt.MedNec.07.11	Approved-Closed	Yes

SERFF Tracking Number:	*UHLC-127355610*	*State:*	*Arkansas*
Filing Company:	*UnitedHealthcare of Arkansas, Inc.*	*State Tracking Number:*	*49472*
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TOI:	*HOrg03 Health - Other*	*Sub-TOI:*	*HOrg03.000 Health - Other*
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Project Name/Number:	*UHC/FPA.Amdt.MedNec.07.11/UHC/FPA.Amdt.MedNec.07.11*		

Form Schedule

Lead Form Number: UHC/FPA.Amdt.MedNec.07.11

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 08/08/2011	UHC/FPA.Amdt.MedNec.07.11	Other	UHC/FPA.Amdt.MedNec.07.11	Initial		52.800	UHC.FPA.Amdt.MedNec.07.11.pdf

AMENDMENT

UnitedHealthcare Insurance Company, contracting on behalf of itself, UnitedHealthcare of Arkansas, Inc., [UnitedHealthcare Plan of the River Valley, Inc.,] and the other entities that are United's Affiliates ("United") and _____ ("Facility") are parties to a facility participation agreement effective _____ (the "Agreement") under which Facility participates in United's network of participating providers.

The parties wish to modify certain provisions of the Agreement.

Now therefore, the parties hereby agree to amend the Agreement as follows:

1. This Amendment is effective on _____, 201_.

2. Section _._ (relating to services not covered under a Benefit Plan) and Section _._ (regarding certain claims denials) are deleted in their entirety.

3. A new section _._, attached to this Amendment as Exhibit 1, is added to the Agreement.

4. To the extent any provision of the Agreement conflicts with the new provision attached as Exhibit 1, the new provision will prevail; however, this paragraph 4 does not apply to conflicts between the new provision and a regulatory appendix.

5. Facility will comply with United's Protocols regarding notification.

6. This Amendment does not initially apply to the following Benefit Plans:

   (1) Benefit Plans issued by United's Affiliates Golden Rule Insurance Company, All Savers Insurance Company, or American Medical Security Life Insurance Company.
   (2) Benefit Plans administered by United's Affiliate UMR, Inc.
   [(3) Benefit Plans described in the Agreement as being subject to an administrative guide other than the UnitedHealthcare Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide (the "Guide"), or Benefit Plans subject to a Supplement to the Guide.]

   If in the future United modifies the utilization management program applicable to certain of the Benefit Plans described above in this section 6, so as to make that program consistent with the utilization management program that applies to the other Benefit Plans subject to this Amendment, United may cause this Amendment to apply to those Benefit Plans by giving 90 days written notice to Facility.

7. The following is added to each state regulatory requirements appendix and applies to all Benefit Plans subject to those Appendices:

   "United and Facility, as applicable, shall comply with applicable law related to utilization management of health care services."

ALL OTHER PROVISIONS OF THE AGREEMENT REMAIN IN FULL FORCE AND EFFECT.

Signatures to follow

UnitedHealthcare Insurance Company, on behalf of itself, UnitedHealthcare of Arkansas, Inc., [UnitedHealthcare Plan of the River Valley, Inc.,] and its other affiliates

Signature: _____
Print Name: _____
Title: _____
Date: _____

Signature: _____
Print Name: _____
Title: _____
Date: _____

[Facility's Legal Name]

Signature: _____
Print Name: _____
Title: _____
Date: _____

Exhibit 1

Denial of Claims for Not Following Protocols, for Not Filing Timely, for Services Not Covered under the Customer's Benefit Plan, or for Lack of Medical Necessity.

(a) Non-compliance with Protocol. Payment may be denied in whole or in part if Facility does not comply with a Protocol or does not file a timely claim as required under this Agreement.

In the event payment is denied under this subsection (a) for Facility's failure to comply with a Protocol regarding notification or regarding lack of coverage approval on file, Facility may request reconsideration of the denial, and the denial under this subsection (a) will be reversed, if Facility can show:

(i) the denial was incorrect because Facility complied with the Protocol; or
(ii) Facility's services were medically necessary (as "medically necessary" is defined in subsection (g)); or
(iii) at the time the Protocols required notification or prior authorization, Facility did not know and was unable to reasonably determine that the patient was a Customer, Facility took reasonable steps to learn that the patient was a Customer, and Facility promptly submitted a claim after learning the patient was a Customer.

The grounds stated in clause (ii) above are also a basis for reconsideration of a denial under subsection (c), (d) or (e) of this section.

The grounds stated in clause (iii) above are also a basis for reconsideration of a denial for lack of timely claim filing under this Agreement.

A claim denied under this subsection (a) is also subject to denial for other reasons permitted under the Agreement; reversal of a denial under this subsection (a) does not preclude United from upholding a denial for one of these other reasons.

(b) Non-Covered Services. Services not covered under the applicable Benefit Plan are not subject to the rates or discounts of this Agreement. Facility may seek and collect payment from a Customer for such services (provided that the Facility obtained the Customer's written consent), except as provided below in subsections (d), (e) and (f).

If a service is not a Covered Service because a discharge order has been written by a physician treating the Customer but the Customer has elected to remain an inpatient, Facility may seek and collect payment from the Customer for those non-Covered Services, but only if, prior to receiving the service, the Customer had knowledge of the discharge order and the lack of coverage for additional inpatient service and specifically agreed in writing to be responsible for payment of those charges.

(c) Denials for Lack of Medical Necessity through the Prior Authorization Process. If a service would otherwise be a Covered Service, but is not a Covered Service under the applicable Benefit Plan because it is determined through the prior authorization process to not meet the Benefit Plan's requirement of medical necessity, as defined in the Benefit Plan or applicable law (or similar concept in the Benefit Plan, such as not consistent with nationally recognized scientific evidence as available, and not consistent with prevailing medical standards and clinical guidelines), Facility may seek or collect payment from the Customer but only if, prior to receiving the service, the Customer had knowledge of the determination of non-coverage and specifically agreed in writing to be responsible for payment of those charges.

(d) Clinical Review of Inpatient Bed Days. If a determination is made after a Customer becomes an inpatient that certain services are not medically necessary (including cases in which a part of an admission is determined to be medically necessary and part of the same admission is determined not to be medically necessary), the claim with regard to services that are not medically necessary (including room, board, and other services for a given day) may be denied and Facility must not seek or collect payment from the Customer. Payment will be made in accordance with the applicable payment appendix for the part of the admission that is determined to be medically necessary, and Facility may collect from the Customer the applicable copayment, deductible or coinsurance for that part of the admission. A claim may also be denied in whole or in part under this subsection (d) in cases in which services cannot be determined to be medically necessary due to omission of information or failure to respond to United's request for information; Facility may request reconsideration of such a denial on grounds of medical necessity.

United will not reduce payment under this subsection (d) when the contract rate for the claim is not impacted by the length of stay, because the contract rate is determined by an MS-DRG or similar methodology and is not subject to an inpatient outlier provision.

(e) Level of Care Determinations. United may determine that the level of care provided for a given service was not medically necessary, because the service could more appropriately have been rendered at a lower level of care (for instance, observation or ambulatory surgery rather than inpatient, or medical/surgical rather than ICU or CCU). If Facility submits a claim for the level of care deemed not medically necessary, United may deny the claim, and Facility will not seek or collect payment from the Customer. A claim may also be denied in whole or in part under this subsection (e) in cases in which services cannot be determined to be medically necessary due to omission of information or failure to respond to United's request for information; Facility may request reconsideration of such a denial on grounds of medical necessity.

(f) **Delay in Service.** If United determines that Facility did not execute a physician's written order in a timely manner and that, as a result, the Customer's inpatient stay was lengthened, United may deny the claims with regard to the bed day(s) at the end of the stay that would not have been needed were it not for the delay in service (including room, board and other services for the given day), and process the claim based on the contract rate that would apply without that day(s); Facility will not seek or collect payment from Customer in excess of the coinsurance, copayment or deductible associated with the claim as processed.

United will not reduce payment under this subsection (f) when the contract rate for a claim is not impacted by the length of stay, because the contract rate is determined by an MS-DRG or similar methodology and is not subject to an inpatient outlier provision.

(g) Definition. As used in subsection (c), "medical necessity" or "medically necessary" will be defined in accordance with the applicable Benefit Plan and applicable law or regulatory requirements.

As used in subsections (a), (d) and (e), "medical necessity" or "medically necessary" is defined as follows:

> Medically Necessary - health care services provided for the purpose of preventing, evaluating, diagnosing or treating a sickness, injury, substance use disorder, condition, disease or its symptoms, that are all of the following as determined by United or its designee, within its sole discretion.
>
> · In accordance with Generally Accepted Standards of Medical Practice.

- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the customer's sickness, injury, substance use disorder, disease or its symptoms.
- Not mainly for the Customer's convenience or that of the customer's physician or other health care provider.
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Customer's sickness, injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on physician specialty society recommendations or professional standards of care may be considered. United reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within United's sole discretion.

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Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	08/08/2011
Comments:			

The form filing achives a Flesch Score of 52.8.

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	08/08/2011
Bypass Reason:	Not Applicable - Provider Agreement Amendment		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	08/08/2011
Bypass Reason:	Not Applicable - Provider Agreement Amendment		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	08/08/2011
Bypass Reason:	Not Applicable - Provider Agreement Amendment		
Comments:			